SENATE BILL No. 580

Introduced by Committee on Insurance (Senators Speier (Chair), Escutia, Figueroa, Johnson, Oller, Perata, Scott, and Soto)

February 20, 2003

An act to amend, repeal, and add Section 1356 of the Health and Safety Code, relating to health care service plans, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 580, as introduced, Committee on Insurance. Health care service plans.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and provides for the department to be supported from the Managed Care Fund. Existing law requires health care service plans to pay an amount each fiscal year as a reimbursement of its share of all costs and expenses reasonably incurred in the administration of the act.

Existing law requires a health care service plan to pay $12,500 plus an amount up to an amount computed in accordance with a specified schedule, and requires a specialized health care service plan to pay $7,500 plus an amount up to an amount computed in accordance with a specified schedule as reimbursement for that cost. Existing law authorizes the director to impose an additional assessment on or before September 15 of each year, for the 2000–01, 2001–02, and 2002–03 fiscal years in order to provide the department with sufficient revenues to support costs and expenses, including maintaining a prudent reserve. Existing law permits the director to require a health care service plan to pay an additional assessment to provide the department with sufficient revenue.

This bill would change the maximum rate for reimbursement for the administration expenses to $10,000 per plan. The bill would require non-specialized health care service plans to pay 65% of the department's costs and expenses for the ensuing fiscal year and specialized plans to pay 35% of the department's costs and expenses for the ensuing fiscal year, calculated on a per enrollee basis. The bill would also require a plan to pay $2,000 plus up to $0.0048 per enrollee of the purpose of reimbursing its share of costs and expenses reasonably anticipated to be incurred by the department in relation to insolvency. The bill would provide that all changes not exceed the cost reasonably incurred in administering the chapter.

This bill would on July 1, 2003, delete the director's authority to require a health care service plan to pay an additional assessment on or before September 15 of each year.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $^2/_3$. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1356 of the Health and Safety Code is amended to read:

1356. (a) Each plan applying for licensure under this chapter shall reimburse the director for the actual cost of processing the application, including overhead, up to an amount not to exceed twenty-five thousand dollars ($25,000). The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the director within 30 days of the date of billing. The director shall not issue a license to any applicant prior to receiving payment in full for all amounts charged pursuant to this subdivision.

(b) *(1)* In addition to other fees and reimbursements required to be paid under this chapter, each licensed plan shall pay to the director an amount as estimated by the director for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, including, but not limited to, costs and expenses associated with routine financial examinations, grievances and complaints including maintaining a toll-free number for consumer grievances and complaints, investigation and enforcement,

medical surveys and reports, and overhead, reasonably incurred in the administration of this chapter and not otherwise recovered by the director under this chapter or from the Managed Care Fund. The amount may be paid in two equal installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year. ~~The~~

(2) The amount paid by each plan~~, except a plan offering only specialized health care service plan contracts, shall be twelve thousand five hundred dollars ($12,500)~~ *shall be ten thousand dollars ($10,000)*, plus an amount up to, but not exceeding, an amount computed in accordance with~~ the following schedule:~~ *paragraph (3).*

~~Plan Enrollment~~	~~Amount of Assessment~~
~~0 to 25,000~~	~~$0 + 65 cents for each enrollee~~
~~25,001 to 75,000~~	~~$16,250 + 53 cents for each enrollee in excess of 25,000~~
~~75,001 to 150,000~~	~~$42,750 + 50 cents for each enrollee in excess of 75,000~~
~~150,001 to 300,000~~	~~$80,250 + 47 cents for each enrollee in excess of 150,000~~
~~over 300,000~~	~~$150,750 + 45 cents for each enrollee in excess of 300,000~~

~~Plans offering only specialized health care service plan contracts shall pay seven thousand five hundred dollars ($7,500), plus an amount up to, but not exceeding, an amount computed in accordance with the following schedule:~~

~~Plan Enrollment~~	~~Amount of Assessment~~
~~0 to 25,000~~	~~$0 + 48 cents for each enrollee~~
~~25,001 to 75,000~~	~~$12,000 + 36 cents for each enrollee in excess of 25,000~~
~~75,001 to 150,000~~	~~$30,000 + 30 cents for each enrollee in excess of 75,000~~
~~150,001 to 300,000~~	~~$52,500 + 26 cents for each enrollee in excess of 150,000~~
~~over 300,000~~	~~$91,500 + 24 cents for each enrollee in excess of 300,000~~

(3) (A) In addition to the amount specified in paragraph (2), all plans, except specialized plans, shall pay 65 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(B) In addition to the amount specified in paragraph (2), all specialized plans shall pay 35 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(4) The amount paid by each plan shall be for each enrollee enrolled in its plan in this state as of the preceding March 31, and shall be fixed by the director by notice to all licensed plans on or before June 15 of each year. A plan that is unable to report the number of enrollees enrolled in the plan because it does not collect that data, shall provide the director with an estimate of the number of enrollees enrolled in the plan and the method used for determining the estimate. The director may, upon giving written notice to the plan, revise the estimate if the ~~commissioner~~ *director* determines that the method used for determining the estimate was not reasonable.

(5) In determining the amount assessed, the director shall consider all appropriations from the Managed Care Fund for the support of this chapter and all reimbursements provided for in this chapter.

(c) Each licensed plan shall also pay two thousand dollars ($2,000), plus an amount up to, but not exceeding, forty-eight hundredths of one cent ($0.0048) for each enrollee for the purpose of reimbursing its share of all costs and expenses, including overhead, reasonably anticipated to be incurred by the department in administering Sections 1394.7 and 1394.8 during the current fiscal year. The amount charged shall be remitted within 30 days of the date of billing.

(d) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this chapter.

(e) The director by notice to all licensed plans on or before September 15 of each year, may require health care service plans to pay an additional assessment to provide the department with sufficient revenues to support costs and expenses as set forth in this

section and subdivision (b) of Section 1341.4 for the 2000–01, 2001–02, and 2002–03 fiscal years. ~~Any~~ *A* plan that did not pay its assessment as required ~~under~~ *by* this subdivision for the 2001–02 fiscal year, shall be assessed the amount due for the 2001–02 fiscal year in the 2002–03 fiscal year, in addition to the amount due in the 2002–03 fiscal year. The assessment pursuant to this subdivision is separate and independent of the assessment in subdivision (b), and may not be aggregated for the purposes of limitation or otherwise with the assessment in subdivision (b). The assessment pursuant to this subdivision is not subject to the limitations imposed on assessments pursuant to Section 1356.1. In imposing an assessment pursuant to this subdivision, the director shall levy on each plan an amount determined by the director using the categories of plans in the schedules set forth in subdivision (b). The assessment shall be paid in full or in two equal installments, as determined by the department. On July 1, 2003, and thereafter, the director may raise the assessment limit pursuant to subdivision (b) to incorporate annual expenditure levels set forth in this subdivision.

(f) For the purpose of calculating the assessment under this section, an enrollee who is enrolled in one plan and who receives health care services under arrangements made by another plan or plans, whether pursuant to a contract, agreement, or otherwise, shall be considered to be enrolled in each of the plans.

(g) This section shall become inoperative on July 1, 2003, and, as of January 1, 2004, is repealed, unless a later enacted statute that is enacted before January 1, 2004, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 1356 is added to the Health and Safety Code, to read:

1356. (a) Each plan applying for licensure under this chapter shall reimburse the director for the actual cost of processing the application, including overhead, up to an amount not to exceed twenty-five thousand dollars ($25,000). The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the director within 30 days of the date of billing. The director shall not issue a license to an applicant prior to receiving payment in full from that applicant for all amounts charged pursuant to this subdivision.

(b) (1) In addition to other fees and reimbursements required to be paid under this chapter, each licensed plan shall pay to the director an amount as estimated by the director for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, including, but not limited to, costs and expenses associated with routine financial examinations, grievances, and complaints including maintaining a toll-free telephone number for consumer grievances and complaints, investigation and enforcement, medical surveys and reports, and overhead reasonably incurred in the administration of this chapter and not otherwise recovered by the director under this chapter or from the Managed Care Fund. The amount may be paid in two equal installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year.

(2) The amount paid by each plan shall be ten thousand dollars ($10,000) plus an amount up to, but not exceeding, an amount computed in accordance with paragraph (3).

(3) (A) In addition to the amount specified in paragraph (2), all plans, except specialized plans, shall pay 65 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(B) In addition to the amount specified in paragraph (2), all specialized plans shall pay 35 percent of the total amount of the department's costs and expenses for the ensuing fiscal year as estimated by the director. The amount per plan shall be calculated on a per enrollee basis as specified in paragraph (4).

(4) The amount paid by each plan shall be for each enrollee enrolled in its plan in this state as of the preceding March 31, and shall be fixed by the director by notice to all licensed plans on or before June 15 of each year. A plan that is unable to report the number of enrollees enrolled in the plan because it does not collect that data, shall provide the director with an estimate of the number of enrollees enrolled in the plan and the method used for determining the estimate. The director may, upon giving written notice to the plan, revise the estimate if the director determines that the method used for determining the estimate was not reasonable.

(5) In determining the amount assessed, the director shall consider all appropriations from the Managed Care Fund for the

support of this chapter and all reimbursements provided for in this chapter.

(c) Each licensed plan shall also pay two thousand dollars ($2,000), plus an amount up to, but not exceeding, forty-eight hundredths of one cent ($0.0048), for each enrollee for the purpose of reimbursing its share of all costs and expenses, including overhead, reasonably anticipated to be incurred by the department in administering Sections 1394.7 and 1394.8 during the current fiscal year. The amount charged shall be remitted within 30 days of the date of billing.

(d) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this chapter.

(e) For the purpose of calculating the assessment under this section, an enrollee who is enrolled in one plan and who receives health care services under arrangements made by another plan or plans, whether pursuant to a contract, agreement, or otherwise, shall be considered to be enrolled in each of the plans.

(f) This section shall become operative on July 1, 2003.

SEC. 3. Nothing in Section 2 of this act modifies or eliminates any obligation of a health care service plan to pay an additional assessment for the 2000–01, 2001–02, or 2002–03 fiscal year pursuant to subdivision (e) of Section 1356 of the Health and Safety Code, as amended by Section 4 of Chapter 1161 of the Statutes of 2002.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to implement the revised reimbursement rates for health care service plans before the 2002–03 fiscal year commences, it is necessary that this act take effect immediately as an urgency statute.

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